U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 May 2003

Case No. 2001-BLA-0758

In the Matter of:
IRVIN POTTER,
Claimant,

v.

SOUTHERN OHIO COAL COMPANY,
Employer,

and

DISTRICT DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

APPEARANCES:
Irvin Potter
Pro se

Elizabeth Thompson
Daughter of Claimant

Christopher Russell, Esq.
On Behalf of Employer

DECISION AND ORDER - DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977,

30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

Procedural History

On April 27, 2001, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 33).[2] A formal hearing on this matter was conducted on October 10, 2002, in Ashland, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis; and

5. Whether the evidence establishes a material change in condition under § 725.309

(DX 33).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2]In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

Background

Irvin Potter ("Claimant") was born on January 12, 1936, and he was 66 years-old at the time of the hearing. (DX 1). He married Joyce (Tolliver) Potter on August 23, 1958, and they remain married. (DX 2; Tr. 18). Mr. Potter completed school through the sixth grade. (Tr. 19). He was hired by Southern Ohio Coal Company, Meigs No. 2 Mine on November 19, 1973, where he initially worked in general repair and welding. (DX 32). He was also a mechanic, an outside mechanic, a wireman, a pumper, and a trackman. On May 12, 1994, Mr. Potter became a motorman, which involved transporting supplies and rock dust, as well as helping rock dust in the entries on sections and abandoned works. (Tr. 21). He retired in May of 1996 from Souther Ohio Coal Company following a car accident resulting in a whiplash injury. (DX 1, 32; Tr. 22).

Mr. Potter no longer uses supplemental oxygen at home, but he does have prescriptions for inhalers and a nebulizer. (Tr. 29). He testified that he has to rest after walking half of the way up a 5% incline to a horse stable located 200 feet behind his house. (Tr. 32). He is able to climb the ladder up to the loft of the stable every morning to throw hay down to his horses. (Tr. 43). Mr. Potter also testified that he smoked a pack of cigarettes per day for 10 years during a period of time 20 years ago. (Tr. 33). Elizabeth Thompson testified that Mr. Potter no longer feeds his horses every morning. (Tr. 53). She also testified that Mr. Potter's physical condition had deteriorated over the two months prior to the hearing to the point that he participates in no physical activity. (Tr. 52, 53).

Procedural History

Claimant first filed an application for benefits under the Act on February 6, 1997. (DX 32). On July 21, 1997, the Office of Workers' Compensation Programs ("OWCP") denied Claimant's application, finding that he did not establish the existence of pneumoconiosis, that he did not establish pneumoconiosis arising out of coal mine employment, and that he did not establish that he was totally disabled due to pneumoconiosis. (DX 32). Claimant did not appeal the denial of his claim and it was administratively closed. He filed his second application for benefits on July 5, 2000. (DX 1). The OWCP denied Claimant's duplicate application on September 14, 2000, finding that Claimant did not establish the existence of pneumoconiosis, that pneumoconiosis arose out of coal mine employment, and that he did not establish that he was totally disabled due to pneumoconiosis. (DX 12). On November 13, 2000, Claimant requested an extension of time to submit further evidence regarding the length of his coal mine employment. (DX 13). In response to Claimant's letter, the OWCP granted Claimant an extension of time until January 15, 2001 to submit additional medical evidence. (DX 14). The OWCP also scheduled an informal conference after receiving a letter from Claimant requesting a hearing. (DX 15, 16). An informal conference was held on January 17, 2001. (DX 26). David Auger, Acting District Director, issued a Memorandum of Conference on March 1, 2001, recommending that Claimant's claim remain denied. (DX 26). On March 9, 2001, Claimant filed correspondence rejecting the findings of the informal conference and requesting a formal hearing. (DX 27). Claimant's claim was transferred to the Office of the Administrative Law Judges on April 27, 2001. (DX 33)

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.492 and 725.493. The District Director identified Southern Ohio Coal Company as the putative responsible operator. (DX 17). Southern Ohio Coal Company has not contested the issue of whether it is the responsible operator. Southern Ohio Coal Company is the employer with whom Mr. Potter spent his last cumulative one year period of coal mine employment and is properly designated as the responsible operator in this case. §725.493(a)(1).

Length of Coal Mine Employment

Mr. Potter was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated that Claimant engaged in at least 23 years of coal mine employment. The record substantiates the stipulation. Therefore, I find that Claimant engaged in coal mine employment for at least 23 years.

MEDICAL EVIDENCE

X-RAY REPORTS[3]

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
DX 32	5/14/97	6/26/97	Gaziano, B-reader	negative
DX 25	1/26/00	2/20/01	Gaziano, B-reader[4]	negative; small calcified granuloma
DX 10	8/15/00	9/6/00	Gaziano, B-reader	negative; small calcified granuloma
EX 1	5/16/01	7/3/01	Zaldivar, B-reader	negative

[3]The record contains Gerald Vallee, M.D.'s interpretation of a chest x-ray dated August 30, 2002. (CX 2). This x-ray interpretation is not classified in accordance with the standards of § 718.102. Therefore, it cannot constitute evidence of the presence or absence of pneumoconiosis. *See* § 718.102(e). The record also contains the chest x-ray interpretation of George Grauel, M.D.. His interpretation also is not classified in accordance with the standards of § 718.102, and therefore cannot constitute evidence of the presence of absence of pneumoconiosis. *Id.*

[4]A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

PULMONARY FUNCTION STUDIES

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 32 4/30/97	Good/ / Yes	61 67"	3.12	3.99	83	78	No
DX 8 8/15/00	Good/ Fair/ Yes	64 67"[5]	2.29	2.90	67	78%	No
EX 1 5/16/01	/ / Yes	65 67"	2.81	3.56	99	79	No
CX 2 8/30/02	/ / Yes	66 65.5"	2.33 2.41*	2.78 2.84*		84 85*	No No

*post-bronchodilator values

ARTERIAL BLOOD GASES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 32	4/30/97	36	104	No
DX 8	8/15/00	38 37*	91 90*	No No
EX 1	5/16/01	36	78	No

*Results obtained with exercise

Narrative Medical Evidence

Amy Pope-Harmon, M.D., of the Ohio State University Department of Internal Medicine, examined Claimant on April 30, 1997. Dr. Pope-Harmon considered a 28 year coal mine employment history and a smoking history of one-half pack of cigarettes per day for 20 years. Claimant complained of progressively worsening dyspnea over the past 10 years as well as intermittent chest pain. Dr. Pope-Harmon noted that Claimant's chest x-rays are without any evidence of interstitial disease, and she commented that they had not changed significantly since

[5] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the miner's actual height is 67 inches.

1990. She concluded that Claimant had dyspnea of unknown cause, but excluded the possibility of a smoking or occupationally acquired disease based on his job description and the x-ray findings. Dr. Pope-Harmon sought a pulmonary function test ("PFT") to confirm her diagnosis. She opined that Claimant's dyspnea may be related to ischemic heart pain, or even a possible relation to Claimant's history of nervousness. Dr. Pope-Harmon scheduled Claimant for a chest x-ray and a PFT.

Claimant underwent a pulmonary exercise evaluation on May 14, 1997. (DX 32). The test was ordered by Dr. Pope-Harmon and conducted by Dr. Pomerantz. The interpretation states that the results were consistent with a relatively normal exercise response. Cardiovascular response was normal. The electrocardiogram ("EKG") was interpreted as showing a normal EKG at rest.

Santpal Mavi, M.D. examined Claimant on August 15, 2000 and completed a Medical History and Examination for Coal Workers' Pneumoconiosis form. (DX 8). Dr. Mavi considered a coal mine employment history of 23 years and a 20 year history of smoking one-half of a pack of cigarettes per day from 1960 to 1980. Claimant complained of sputum production, dyspnea, cough, chest pain, and occasional paroxysmal nocturnal dyspnea. Claimant stated that he could walk about 1 mile with a slow pace and that he could carry a 20 pound weight for 200 feet. Dr. Mavi noted that Claimant underwent cardiac catheterization in 1999. Claimant's lungs were clear to auscultation. Dr. Mavi detected significant dyspnea on exertion and prolonged expiratory phase. He submitted Claimant to a chest x-ray, PFT, and arterial blood gas study ("ABG"), and an EKG. He interpreted the chest x-ray as revealing prominent lung markings, with a faint nodular density in the left lower lobe. Dr. Mavi diagnosed chronic obstructive pulmonary disease ("COPD") based on a history of smoking, coronary artery disease based on a history of chest pain, and pneumoconiosis based on a history of working in coal mines. It is clear, however, that he based his three diagnosis on more than that. He utilized his history, examination and objective medical tests to reach his conclusions. Dr. Mavi opined that Claimant would be unable to perform any physical job due to severe shortness of breath and dyspnea on exertion and chest pain. He also opined that Claimant's COPD was responsible for 25% of his impairment, that his coronary artery disease was responsible for 50-60% of his impairment, and that pneumoconiosis is responsible for 20-25 % of his impairment.

The record contains a billing statement from the Holzer Clinic authorized by Dr. Mavi on July 7, 2000. (DX 21). On the document, a level 3 physical exam for an existing patient is circled. COPD is also circled with an asterisk next to it, and below is an * with the words "chronic obstructive pulmonary disease" written next to it. "Pneumoconiosis" is also written on the document and highlighted in yellow.

The record contains a second billing statement from the Holzer Clinic authorized by Dr. Mavi on September 6, 2000 noting that Claimant's last visit was on August 29, 2000. (DX 21). On the statement, a level 2 physical exam of an existing patient is circled, as well as pulse oximetry, anxiety disorder, and COPD. At the bottom of the statement, the word "Pneumoconiosis" is written in and highlighted in yellow.

Claimant addressed a letter to Dr. Mavi on January 1, 2001, requesting answers from Dr. Mavi to 6 questions regarding Dr. Mavi's August 15, 2000 report. On the top of the typed document, in handwriting, are the words "Dr. Mavi refused to answer questions."

On November 20, 2000, Ralph Lach, M.D. sent a letter to Claimant, reminding Claimant that he had informed Claimant that Claimant's coronary arteries had diffuse plaque disease with no evidence of a significant obstructive problem. (DX 20).

George Zaldivar, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant on May 16, 2001. (EX 1). Claimant complained of pressure and burning in the middle of his chest for the past 11 years, shortness of breath on exertion, and a morning cough productive of sputum. Dr. Zaldivar considered a coal mine employment history of 27 years and a smoking history beginning at age 15 and ending 20 to 25 years ago. He submitted Claimant to a chest x-ray, a PFT, and an ABG that included an exercise test which was aborted. Dr. Zaldivar interpreted the x-ray as negative for the existence of pneumoconiosis. He noted that spirometry was normal with a mild restriction of total lung capacity, and that the ABG showed a moderate diffusing impairment. Claimant's lungs were clear to auscultation. Dr. Zaldivar's impression was history of chest pain, normal examination of the lungs, and history of shortness of breath.

Dr. Zaldivar issued a narrative report on July 5, 2001 after reviewing and summarizing Claimant's medical records. (EX 1). He listed his own findings, incorporating his impression from his May 16, 2001 exam, as well as noting: 1). low carboxyhemoglobin of a current non-smoker; 2). normal spirometry; 3). Mild restriction of total lung capacity; 4). moderate diffusion impairment; 5). paroxysmal supraventricular tachiycardia during the exercise at the low level of work, but with normal blood gases at that point; 6). no radiographic evidence of pneumoconiosis. He added, however, that there is radiographic evidence of pulmonary fibrosis[6], which is represented by the linear markings at the mid and lower lung zones with early honeycombing, particularly on the left. Dr. Zaldivar noted that the records indicated that Claimant suffered from emphysema, even though there is no objective evidence. He asserted that Claimant uses a bronchodilator, which Claimant does not need according to the breathing test he reviewed. Dr. Zaldivar stated that the spirometry showed no obstruction, and the lung volumes revealed no air trapping that could in any way suggest the presence of pneumoconiosis. On the other had, Dr. Zaldivar noted that Claimant has a low diffusion capacity by spirometry and abnormal chest x-ray findings compatible with pulmonary fibrosis. He concluded that Claimant's symptoms of dizziness are the result of supraventricular tachycardia occurring intermittently. Dr. Zaldivar concluded that Claimant does not have CWP, no any chronic dust disease of the lung. He found that Claimant was disabled from performing his usual coal mine employment, but that this disability stems from cardiac arrhythmia, which is unrelated to any pulmonary condition. Dr.

[6]Pulmonary fibrosis is a specific form of chronic fibrosing interstitial pneumonia limited to the lung. Signs of pulmonary fibrosis include abnormal chest x-rays, restrictive lung disease, and diminished diffusion capacity. *See UpToDate; ATS Guidelines: idiopathic pulmonary fibrosis: diagnosis and treatement,* Vol. 10, No. 2. (EX 2).

Zaldivar found that a pulmonary condition does exist, which needs to be investigated in detail by a CT of the chest to confirm his diagnosis of pulmonary fibrosis. Dr. Zaldivar also concluded that Claimant's pulmonary fibrosis is not the result of CWP or any dust disease of the lung.

Gerald Vallee, M.D. examined Claimant on August 30, 2002, upon a referral from Dr. Evans. Claimant complained of a bad breathing problem dating back several years with recent exacerbation. He noted that Claimant had a long history of shortness of breath on exertion and cough dating back 12-13 years. Claimant has also had chest pain. Dr. Vallee considered a smoking history of one-half pack of cigarettes per day from 1955 until 1975. He performed a physical examination and detected very fine inspiratory and expiratory rales over the lower half of the right lower lobe and 1/3-1/2 of the left lower lobe. He noted that a CT scan of the chest revealed left sided pleural effusion and a chest x-ray showed infiltrates both finely linear and finely nodular consistent with pulmonary fibrosis and or pneumoconiosis. He conducted a PFT. Dr. Vallee listed the following impression: 1). Restrictive lung disease of moderate proportions with no evidence of COPD. Significant decrease in diffusion associated with an abnormal chest x-ray demonstrating infiltrates consistent with CWP and or silicosis and or pulmonary fibrosis; 2). Recent significant weight loss associated with pneumonia. Now probably resolved; 3). History of lymphadenopathy on CT scan of the chest; 4). Lesions located in areas unrelated to a respiratory or pulmonary impairment which he was advised to have evaluated; 5). Hyperlipidemia. Under treatment; and 6). Anxiety and depression under treatment. Dr. Vallee voiced agreement with Claimant's regimen and stated that he believes that Claimant has CWP. He noted that a differential diagnosis could be pulmonary fibrosis, but he thinks the best possibility is CWP complicated with silicosis from his coal dust and silica exposure with his long mining experience. He noted that Claimant had a history of 30 years in the coal mines, and that Claimant had not smoked in 20 years, and there is no evidence of obstruction on PFTs. Dr. Vallee recommended a follow-up PFT in 3 months, after which, if there was significant deterioration on his PFTs or if he has persistent or increased abnormalities on CT of the chest, then Dr. Vallee would recommend a lung biopsy to rule out a possible treatable lesion superimposed on his chronic lung lesions

David Evans, M.D. stated on October 4, 2002 that Claimant was under his medical care for pneumoconiosis, restrictive lung disease, persistent cough, abnormal chest x-ray, and shortness of breath. (CX 1). Dr. Evans noted considered that Claimant had a 30 year history of coal mine employment, including some mines with silica. He noted that Claimant is using two prescription inhalers and a nebulizer for his difficulty breathing. He referred Claimant to Dr. Vallee, who concurred with Dr. Evans diagnosis of CWP after Dr. Vallee examined Claimant.

Dr. Zaldivar issued a second consultative, narrative report on October 21, 2002 after reviewing his previous report and Claimant's medical records. Dr. Zaldivar summarized Claimant's medical records. He attached an article from the *Electronic Textbook of Pulmonary Medicine*, which was entitled *UpToDate; ATS guideline: Idiopathic pulmonary fibrosis: Diagnosis and treatment*, to show that Claimant's pulmonary disorder meets only one diagnosis, which is the diagnosis of pulmonary fibrosis. He cited to the epidemiological area of the article on page 3 to note that pulmonary fibrosis is a common disease. Dr. Zaldivar stated that Claimant's history fits the diagnosis because he has shortness of breath that is non-specific, he has a chronic cough, and chest x-rays and CAT scans show no abnormalities except pulmonary fibrosis. Dr. Zaldivar stated that the "so-called pneumonia was no more than the symptoms of the same

pulmonary fibrosis which [Claimant] has, complicated by acute bronchitis perhaps." Dr. Zaldivar stated that Claimant's chest x-ray fits well with Claimant's case, and he referenced the peripheral reticular opacities described by Dr. Vallee. He noted that Dr. Vallee considered pulmonary fibrosis as a differential diagnosis and questions why Dr. Vallee did not obtain a pulmonary biopsy to conclusively diagnose Claimant's pulmonary condition. Dr. Zaldivar documented the progression of Claimant's restrictive lung disease based on his declining FVC value and the absence of an obstructive lung disease. He asserted that rapid deterioration of lung function without any airway obstruction with progressive restriction is typical of pulmonary fibrosis.

Dr. Zaldivar again referenced the article and concluded that Claimant's PFTs fit the diagnosis of pulmonary fibrosis very well because the vital capacity is reduced as well as the total lung capacity. He also noted that Claimant's diffusing capacity is very much reduced and is in agreement with the reduction of the lung volumes. He recommends that a high resolution CT scan and a pulmonary biopsy be performed. Dr. Zaldivar referenced Part III of the article, which deals with differential diagnosis, to note that CWP is not listed as a differential diagnosis because CWP does not cause pulmonary fibrosis, nor is it related to CWP in any way. He added that, in contrast to pulmonary fibrosis, CWP results in airway obstruction. He referenced a NIOSH article, which notes that coal Claimants have an increased risk for developing COPD. Dr. Zaldivar concluded that Claimant does not have any such airway obstruction based on his report and Dr. Vallee's report. He stated that he is concerned with Claimant's great loss of pulmonary function in less than a year between his report and Dr. Vallee's report. He concluded that such a loss means that pulmonary fibrosis is progressing at a fast rate and if a diagnosis is to be attempted, a lung biopsy should be performed soon. Dr. Zaldivar stated that all of the opinions contained in his prior report remain the same. He also opined that Claimant does not suffer from CWP nor silicosis. Claimant suffers from coronary artery disease which resulted in syncope and is causing him chest pains and pressure. He concluded that Claimant also has pulmonary fibrosis unrelated to his occupation as a coal Claimant.

Hospital Records

On January 1, 1998, Claimant was admitted to the Columbia Medical Center in Sanford, Florida because of chest pain and history of blackouts. Claimant underwent a catheterization which showed a 50-60% occlusion of the right coronary artery and left anterior descending, which can be managed medically. A chest x-ray performed while Claimant was there was noted to be clear by Robert Haller, M.D.. He was discharged on January 8, 1998 with final diagnoses of moderate coronary artery disease, emphysema, gastroesophageal reflux disease, and history of syncope, possibly vasovegal.

Claimant was admitted to the Holzer Medical Center on May 29, 2002 with diagnosis of left lower lobe pneumonia and pneumoconiosis. He underwent a chest x-ray and a CT scan of his chest. Physical examination of Claimant's chest on discharge revealed bibasilar rales. Claimant was discharged on June 3, 2002 with diagnoses of: 1). left lower lobe and left upper lobe pneumonia; 2). mediastinal lymphadenopathy; 3). Chronic obstructive pulmonary disease/pneumoconiosis; 4). Anxiety intentional (?) state; 5). history of hypertension; 6). GERD; and 7). History of chronic back pain secondary to motor vehicle accident. G. Jayaraman, M.D.'s impression upon discharge was that Claimant had left lower lobe infiltrate, pneumoconiosis, and

he sought to rule out myocardial infarction and dementia. Dr. Jayaraman had examined Claimant in the emergency room on May 28, 2002 before admitting Claimant due to increasing chronic cough over the past three weeks, increasing sputum production, and fever.

Choud Rayani, M.D. ordered a CT scan of Claimant's chest for the purpose of diagnosing pneumoconiosis on May 29, 2002 while Claimant was at the Holzer Medical Center. (CX 3). The impression of the CT scan noted that a small left-sided pleural effusion and some moderate primarily interstitial opacification present principally in the left lung may be related to Claimant's history of pneumoconiosis. The impression also stated that it is difficult to rule out an acute inflammatory process.

DISCUSSION AND APPLICABLE LAW

Mr. Potter's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, the following elements:

1. That he suffers from pneumoconiosis;

2. That the pneumoconiosis arose, at least in part, out of coal mine employment;

3. That he is totally disabled; and

4. That the total disability is caused by pneumoconiosis.

See §§ 719.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Duplicate Claim

Claimant's July 5, 2000 application for benefits under the Act was filed more than one year after the final denial of his previous application for benefits was denied on July 21, 1997. The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). Section 725.309(d) provides that:

> If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of § 725.310 are met.

The Benefits Review Board defined "material change in conditions" under § 725.309(d) as occurring when a claimant establishes, by a preponderance of the evidence developed subsequent to the prior denial, at least one of the elements of entitlement previously adjudicated against the claimant. *See Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). The Board has also held that a material change in conditions may only be based upon an element which was previously denied. *Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) (where Administrative Law Judge found that claimant did not establish pneumoconiosis and did not specifically address total disability, the issue of total disability may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions). Lay testimony alone is insufficient to establish a material change in conditions. *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999).

This matter arises under the jurisdiction of the Sixth Circuit Court of Appeals.[7] In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit held that, under *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), it is insufficient for the ALJ to merely analyze the newly submitted evidence to determine whether an element previously adjudicated against the claimant has been established. An administrative law judge must also compare the sum of the newly submitted evidence against the sum of the previously submitted evidence to determine whether the new evidence is substantially more supportive of claimant. *Id*.

In Claimant's prior application, benefits were denied because Claimant did not establish the existence of pneumoconiosis, that pneumoconiosis arose out of coal mine employment, and because Claimant did not establish that he was totally disabled due to pneumoconiosis. Therefore, in order for Claimant to establish a material change in conditions, he must establish one of these elements that was previously adjudicated against him, and the new evidence must be substantially more supportive of his claim. If Claimant does establish a material change in condition, then the entire record must be reviewed *de novo* to determine if he is entitled to benefits under the Act.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

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[7]Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc). Miner last engaged in coal mine employment in Kentucky.

> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The newly submitted evidentiary record consists of 3 interpretations of three x-rays, all of which were rendered by B-readers. All three B-readers interpreted the x-rays as negative for the existence of pneumoconiosis. Therefore, I find that the Claimant has not established the existence of pneumoconiosis by x-ray evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The newly submitted evidentiary record does not contain any biopsy evidence to consider. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary

function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). The newly submitted evidentiary record consists of several medical opinions.

Dr. Mavi opined that Claimant suffered from pneumoconiosis based on his history of working in the mines. He also diagnosed COPD based on a history of smoking. He wrote "COPD" and "pneumoconiosis" on Claimant's billing statements. Dr. Mavi examined Claimant, submitted him to objective testing, and considered an accurate account of Claimant's smoking and coal mine employment history. He set forth clinical observations and findings. While Dr. Mavi appears to have relied solely on a history of coal mine employment to diagnose pneumoconiosis, which would prevent his opinion from being reasoned and documented, he performed an examination and ordered tests which I conclude did form other bases for his diagnosis. The hand-written notations of pneumoconiosis and COPD on the printed billing statements alone are unreliable evidence and are not supported by any reasoning or documentation. Moreover, COPD based on a history of smoking does not constitute a diagnosis of pneumoconiosis. I find that while Dr. Mavi's opinion does support a finding of the existence of pneumoconiosis, it is only entitled to limited weight since he did not clearly relate the results of the examination and tests to his diagnosis of pneumoconiosis.

Dr. Zaldivar concluded that Claimant does not suffer from pneumoconiosis. Rather, he opined that Claimant suffers from pulmonary fibrosis, which he stated is a chronic disease of the lungs unrelated to coal dust exposure. Dr. Zaldivar examined Claimant, submitted Claimant to objective testing, and relied upon medical literature discussing the disease of pulmonary fibrosis. He considered an accurate account of Claimant's smoking and coal mine employment history, and he reviewed Claimant's medical records. Dr. Zaldivar set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is well-reasoned and well-documented. I find that Dr. Zaldvivar's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Rayani interpreted a CT scan of Claimant's chest as revealing left-sided pleural effusion and interstitial opacification that may be related to Claimant's history of pneumoconiosis. However, he stated that it is difficult to rule out an acute inflammatory process. Dr. Rayani's interpretation is not a conclusive diagnosis of pneumoconiosis. On its own, it is not sufficient to establish the existence of pneumoconiosis, but it lends evidentiary support to such a diagnosis.

Dr. Vallee examined Claimant upon referral from Dr. Evans. He voiced his agreement with Dr. Evans that Claimant suffers from CWP. Dr. Vallee detected bilateral rales in Claimant's lungs, and he reviewed radiographic and CT scan evidence which he interpreted as being consistent with pulmonary fibrosis or pneumoconiosis. He conducted a PFT, which he determined showed a restrictive lung disease of moderate proportions. He also found that Claimant suffered from a significant decrease in diffusion capacity. Dr. Vallee considered the diagnosis of pulmonary fibrosis, but determined that CWP complicated with silicosis was the better diagnosis from his coal dust and silica exposure with his long mining experience. He noted that Claimant had not smoked in 20 years and that the PFTs did not show an obstructive disease. He examined Claimant, submitted Claimant to and reviewed the results of objective testing, and he considered an accurate account of Claimant's smoking and coal mine employment histories. Dr. Vallee set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is well-reasoned and well-documented. I find that Dr. Vallee's opinion is entitled to probative weight.

Dr. Evans stated that Claimant was under his medical care for pneumoconiosis, restrictive lung disease, persistent cough, abnormal x-ray, and shortness of breath. He noted Claimant's 30 year history of coal mine employment, as well as Claimant's prescription inhalers and nebulizer. Dr. Evan's treatment records are not contained in the record. His report is not sufficiently well-reasoned or well-documented to constitute probative evidence of the existence of pneumoconiosis. However, it is sufficient to serve as complementary evidence in support of a finding of pneumoconiosis.

Dr. Jayaraman diagnosed the existence of pneumoconiosis while he was Claimant's attending physician when Claimant was hospitalized. He reviewed the results of a chest x-ray and a CT scan, which he found to be consistent with pneumoconiosis.. He also noted Claimant's complaints of an increasing chronic cough and sputum production. He detected bibasilar rales in Claimant's lungs on discharge. Dr. Jayaraman set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is well-reasoned and well-documented. I find that Dr. Jayaraman's opinion is entitled to probative weight.

I find that Claimant has established the existence of pneumoconiosis by a preponderance of the evidence. The well-reasoned and well-documented opinions of Drs. Jayaraman and Vallee establish the existence of pneumoconiosis. Their opinions are provided with a modicum of support by Dr. Rayani's CT scan interpretation and the opinions of Drs. Evans and Mavi. The combined weight of these opinions establishes the existence of pneumoconiosis. The enhanced weight accorded to Dr. Zaldivar's opinion is not sufficient to overtake the combined weight of the evidence finding the existence of pneumoconiosis.

Drs. Vallee and Zaldivar both considered CWP and pulmonary fibrosis as differential diagnoses, before reaching opposing conclusions. Dr. Zaldivar excluded CWP as a diagnosis, stating that CWP causes an airway obstruction when it causes a pulmonary impairment. He also stated, "[i]n contrast to the pulmonary findings of pulmonary fibrosis, coal workers' pneumoconiosis results in airways obstruction." Furthermore, Dr. Zaldivar cited to a NIOSH article that notes that coal miners have an increased risk of developing COPD. He pointed out that Claimant did not have any evidence of airway obstruction based on his breathing tests. The

definition of legal pneumoconiosis "includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." § 718.201(a)(2). The definition of pneumoconiosis encompasses a restrictive lung disease. Dr. Zaldivar based his opinion that Claimant does not have CWP on a limited definition of pneumoconiosis. In contrast, Dr. Vallee diagnosed the existence of CWP even though he specifically noted the absence of any evidence of obstruction on PFTs. Dr. Vallee's opinion indicates that he considered the entire spectrum of the definition of pneumoconiosis. Therefore, I find that Dr. Vallee's opinion is better reasoned in comparison to Dr. Zaldivar's opinion. The credentials of Dr. Zaldivar contained in the record initially garner his opinion enhanced weight. But in comparison to Dr. Vallee's report, I find Dr. Vallee's opinion to be controlling. Furthermore, Dr. Vallee's opinion is supported by the well-reasoned and well-documented opinion of Dr. Jayaraman.

I find that Claimant has established, by a preponderance of the evidence, the existence of pneumoconiosis under subsection (a)(4). By establishing the existence of pneumoconiosis, Claimant has established an element of entitlement previously adjudicated against him. However, in order to establish a change in conditions, the newly submitted evidence must show a worsening of Claimant's condition by being substantially more supportive of his claim.

The previously submitted evidence consists of one negative x-ray interpretation by Dr. Graziano a non-qualifying PFT, a non-qualifying ABG, and the narrative report of Dr. Pope-Harmon, who excluded a diagnosis of an occupational lung disease as the cause of Claimant's dyspnea. There was a complete lack of any evidence to support a finding of pneumoconiosis. The newly submitted evidentiary record documents a progressively worsening restrictive lung disease arising out of coal mine employment. Several physicians diagnosed pneumoconiosis. The newly submitted evidence is substantially more supportive of Claimant's application. Claimant's condition has worsened since the prior denial of benefits. Therefore, I find that Claimant has established a material change in condition. I will now review the evidence of record *de novo* to determine if Claimant is entitled to benefits under the Act.

Smoking History

Claimant testified to smoking one-half pack of cigarettes per day for a ten year period that ended 20 years ago. (Tr. 33). Drs. Mavi, Pope-Harmon, and Vallee noted that Claimant smoked one-half pack of cigarettes per day for 20 years. Dr. Zaldivar reported that Claimant began smoking in 1951 and stopped somewhere between 1976 and 1981. I find that Claimant smoked one-half pack of cigarettes per day for 20 years.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established 23 years of coal mine employment, and as no

rebuttal evidence was presented, I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(b).

Total Disability

Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both "like" and "unlike" must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

The record does not contain any evidence of complicated pneumoconiosis to consider. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. The record contains 4 PFTs, none of which produced qualifying values. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) by the results of arterial blood gas studies. The record contains 3 ABGs, none of which produced qualifying values. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence of cor pulmonale with right-sided congestive heart failure to consider. Therefore, I find that Claimant has not established the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that Miner's respiratory or pulmonary condition prevented Miner from engaging in his usual coal mine employment or comparable gainful employment. Miner's usual coal mine employment consisted of work as a mechanic and a motorman, which involved transporting supplies and rock dusting on the entry ways and abandoned works. Claimant completed a Description of Coal Mine Employment form. (DX 5). He noted that sat for 2 hours, walked for 4-5 hours, and crawled short distances. Claimant also noted that he would lift objects weight 50-70 pounds an average of 2-60 times per week.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable

to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

In 1997, Dr. Pope-Harmon stated that Claimant suffered from dyspnea, but she did not identify any level of impairment. Three years later, in 2000, Dr. Mavi diagnosed the existence of CWP and COPD. He opined that Claimant would be unable to perform any physical job due severe shortness of breath, dyspnea on exertion, and chest pain. Dr. Mavi performed a physical examination, submitted Claimant to objective testing, and considered an accurate account of Claimant's smoking and coal mine employment histories. Dr. Mavi set forth clinical observations and findings. However, his opinion relies mainly upon subjective data supplied by the Claimant regarding his physical symptoms and limitations. I find that Dr. Mavi's opinion is entitled to a lesser degree of probative weight.

Dr. Zaldivar examined Claimant on May 16, 2001, finding a mild restriction of total lung capacity and a moderate diffusion impairment. In his initial report, Dr. Zaldivar noted Claimant's complaints of dizziness and attributed them to supraventricular tachycardia that occurs intermittently. He opined that Claimant was disabled from performing his usual coal mine employment due to Claimant's cardiac arrhythmia, which is unrelated to any pulmonary condition. Dr. Zaldivar also opined that Claimant suffers from pulmonary fibrosis, to which he attributed Claimant's lung restriction and diffusion impairment. Dr. Zaldivar issued a second report after reviewing Claimant's medical records, again diagnosing pulmonary fibrosis. He found that Claimant had shortness of breath, a reduced vital capacity, a reduced total lung capacity, and a diffusing capacity that is very much reduced. He documented a great loss of pulmonary function in less than a years time since he issued his first report. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is well-reasoned and well-documented. I find that Dr. Zaldivar's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist..

Dr. Vallee diagnosed the existence of a moderate restrictive lung disease with a significant decrease in diffusion. He examined Claimant and conducted a PFT and an ABG. Dr. Vallee set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is well-reasoned and well-documented. I find that Dr. Vallee's opinion is entitled to probative weight.

Dr. Jayaraman diagnosed the existence of pneumoconiosis, but he did not provide an opinion to consider as to whether Claimant was totally disabled, nor did he provide an opinion on the level of disability caused by Claimant's pneumoconiosis.

Claimant testified that he is unable to do any physical work. He also testified that he

climbs the ladder to the loft of his barn to pitch hay down to his horses. His daughter testified that Claimant is no longer able to pitch the hay for the horses. Drs. Vallee and Zaldivar both detected a restrictive lung disease, as well as a moderate amount of diffusion impairment. Their opinions confirm Claimant's subjective complaint of shortness of breath on exertion. Claimant's usual coal mine employment involved manual labor, which required heavy-lifting on a regular basis. Based on the opinions of Drs. Vallee and Zaldivar, Claimant has a mild restrictive lung disease and a moderate diffusion impairment. I find that Claimant's pulmonary impairment prevents him from performing his usual coal mine employment. There is no evidence of comparable gainful employment to consider. Therefore, I find that Claimant is totally disabled under subsection (b)(2)(iv). Even though Claimant's PFT and ABG values are not qualifying, I find that the narrative opinion evidence establishes, by a preponderance of all of the evidence, that Claimant is totally disabled.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis. Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2).

The Sixth Circuit has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due 'at least in part' to his pneumoconiosis. *Cf*. 20 C.F.R. 718.203(a)." *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's "impairment is due to his combined dust exposure, coal workers' pneumoconiosis as well as his cigarette smoking history" is sufficient). The Sixth Circuit, more recently in interpreting the amended provision at § 718.204(c), determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk}*, 264 F.3d 602 (6th Cir. 2001). The miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and that Miner was totally disabled are more reliable for assessing the etiology of

Miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

In 1997, Dr. Pope-Harmon excluded occupational lung disease as a cause of Claimant's dyspnea based on her examination of Claimant and her interpretation of Claimant's x-rays. Her opinion sets forth clinical findings and observations, and her reasoning is supported by adequate data. Her opinion is well-reasoned and well-documented. However, as I have found the existence of pneumoconiosis and based on the age of the report, I find that Dr. Pope-Harmon's opinion is entitled to a lesser degree of probative weight.

Dr. Mavi found that Claimant was unable to perform any physical job due to severe shortness of breath, dyspnea on exertion, and chest pain. He opined that pneumoconiosis was responsible for 20-25% of his impairment, attributing the balance to COPD and coronary artery disease. Dr. Mavi's diagnosis of pneumoconiosis was not well-reasoned or well-documented. Even though Dr. Mavi performed an examination and conducted testing, he did not identify any findings or data that he relied upon when apportioning the percentage that pneumoconiosis contributes to Claimant's disability. Therefore, I find that Dr. Mavi's opinion is entitled to a lesser degree of probative weight.

Dr. Zaldivar found that a pulmonary condition does exist, pulmonary fibrosis, which he opined is not the result of CWP or any dust disease of the lung. He also found that Claimant's pulmonary fibrosis is not the cause of total disability Dr. Zaldivar's opinion is well-reasoned and well-documented. His opinion is entitled to probative weight, but is less reliable than the opinion of a physician who found the existence of pneumoconiosis and who found a totally disabling respiratory impairment.

Dr. Vallee found that Claimant suffered from a moderate restrictive lung disease and a significant decrease in diffusion capacity. He opined that CWP is the best possibility when considering differential diagnoses of CWP or pulmonary fibrosis. However, Dr. Vallee recommended a follow-up visit in three months to see if Claimant's pulmonary function significantly deteriorated or if there is an increase in the abnormalities present on x-ray to rule out a possible treatable lesion superimposed on his chronic lung lesions. Dr. Zaldivar, who reviewed Claimant's medical records after Claimant visited Dr. Vallee commented that Claimant's rapid deterioration in pulmonary function is an indicator of progressive pulmonary fibrosis.

Dr. Jayaraman diagnosed the existence of pneumoconiosis, but did not provide an opinion as to the level of Claimant' disability.

I find that there is insufficient evidence to establish that Claimant's totally disabling respiratory impairment is due at least in part to his pneumoconiosis. Dr. Vallee finds CWP to be the best possibility of diagnosis, but he did not rule out the possibility of diagnosing pulmonary fibrosis or a superimposed lesion. Dr. Zaldivar, who had the benefit of reviewing Claimant's medical records, identified a progression of pulmonary function decline, which Dr. Vallee was watching for in order to diagnose the existence a superimposed lesion. There is simply an insufficient amount of reliable medical evidence to establish that Claimant is totally disabled due to pneumoconiosis.

Entitlement

The Claimant, Irvin Potter, has failed to prove, by a preponderance of the evidence, that he suffers from a totally disabling respiratory or pulmonary impairment caused by pneumoconiosis. Therefore, Mr. Potter is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Irvin Potter for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**